

17001

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **2383**

ED JUN 7 1948

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day** (Specify whether
In this community **1 day** years, months or days)

3. (a) PRINT
FULL NAME

(b) If veteran,
name war **no**

(c) Social Security
No. **none**

4. Sex **F** 5. Color or race **Or**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **St. Katz**
6. (c) Age of husband or wife if alive **33** years
7. Birth date of deceased **July 15, 1912**
(Month) (Day) (Year)

8. AGE: Years **30** Months **10** Days **10** If less than one day
hr. min.

9. Birthplace **New York** (City, town, or county) **4-71** (State or foreign country)

10. Usual occupation **Teacher**

11. Industry or business **Public School**

MOTHER FATHER

12. Name **Saul Z. Allenson**

13. Birthplace **Poland** (City, town, or county) (State or foreign country)

14. Maiden name **Hena Chepp** (City, town, or county) (State or foreign country)

15. Birthplace **Penn** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. S. Z. Allenson**

(b) Address **1204 Ocean Parkway Brooklyn 4**

17. (a) **Removal** (b) Date thereof **5-25-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New York**

18. (a) Signature of funeral director **Carroll Davidson**

(b) Address **2024 7 road**

19. (a) **May 25 1943** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **N.Y.** (b) County **999**
(c) City or town **Brooklyn** (If outside city or town limits, write "RURAL") **30**
(d) Street No. **1204 Ocean Parkway** (If rural, give location) **2**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **25**
year **1943** hour **11** minute **30 a** M.
21. I hereby certify that I attended the deceased from **May 24**
1943 to **May 25** 19**43**
that I last saw her alive on **May 25** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to **Acute Nephritis** months
Due to **Arthritis** 5 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **F. B. Wallace** (M. D. or other)
Address **703 Hathrop Bldg KC Mo** Date signed **5/25/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Julian T. Davidson

Licensed Embalmer No. 1168

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.